Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

JEREMIAH PEREZ
11011 PLEASANT COLONY #1304
JERSEY VILLAGE, TX 77065

Respondent Name:

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number:

M4-12-0938-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "injury related"

Amount in Dispute: $43,589.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "DWC Rule 133.307 at (b) defines who may request medical fee disputes: "…(1) the health care provider (provider), or a qualified pharmacy processing agent, as described in Labor Code §413.0111, in a dispute over the reimbursement of a medical bill(s); (2) the provider in a dispute about the results of a Division or carrier audit or review which requires the provider to refund an amount for health care services previously paid by the insurance carrier; (3) the injured employee (employee) in a dispute involving an employee's request for reimbursement from the carrier of medical expenses paid by the employee; or (4) the employee when requesting a refund of the amount the employee paid to the provider in excess of a Division fee guideline." Number (1) and (2) do not apply. Number (3) does not apply because there is no evidence in the DWC-60 nor in Texas Mutual's claim file of the claimant having paid out of pocket medical expenses related to the compensable injury. And (4) is not applicable as there is no evidence of a payment amount by the claimant to the hospital in an excess of a Division fee guideline. The claimant has no standing in the fee dispute between Texas Mutual and Cypress Fairbanks Medical Center. For this reason his request should be dismissed."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 25, 2010 through December 3, 2010	Unpaid medical bills	$43,589.82	0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures injured employees to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured employees to submit workers' compensation out-of-pocket expenses for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits were not submitted by either party.

Issues

1. Did the requestor submit the request for medical fee dispute resolution for the services in dispute in accordance with 28 Texas Administrative Code §133.307?
2. Is the requestor entitled to reimbursement?

Findings

Review of the documentation submitted by both parties shows that the injured employee has not incurred any out-of-pocket expenses for his Workers' Compensation injury. Therefore, in accordance with 28 Texas Administrative Code §133.307(e)(3)(B) the requestor is not a proper party to the dispute pursuant to subsection (b) of this section.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 13, 2011
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luevano	December 13, 2011
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.